DIABETIC EYE DISEASE PROGRAM (DEDP)

MANUAL

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TEXAS Department of State Health Services

DIABETIC EYE DISEASE PROGRAM

TEXAS DIABETES COUNCIL

www.texasdiabetescouncil.org

DIABETIC EYE DISEASE PROGRAM

OVERVIEW

The Texas Diabetes Program/Council established the Diabetic Eye Disease Program (DEDP) in 1989 to help prevent blindness through early identification of diabetic eye disease in people who lack other resources for an annual eye exam. In its first year, the program provided exams for less than 500 persons at risk for diabetic eye disease. By 2003, the program was providing its current level of almost 6,000 exams per year.

The DEDP is administered by the Diabetes Program at the Texas Department of State Health Services, 1100 West 49th Street, Austin, Texas. Approximately 350 ophthalmologists and licensed optometrists in Texas currently agree to provide reduced-costs exams to individuals who meet program eligibility requirements.

This manual provides guidelines for both *Nominators* (Section 2) and *Providers* (Section 4) of service.

Nominators are staff of DSHS health service regions, local health departments, and state and federally supported primary care facilities who:

- determine eligibility of program clients,
- refer them to eye care providers,
- follow up with clients and providers to assure that eye exams are provided,
- assist clients in obtaining follow-up exams and /or treatment,
- and track clients referred for follow-up.

Providers are opthalmologists and optometrists contracted by DSHS to perform eye examinations for eligible clients referred by nominators.

- **Nominator and Provider Guidelines** found in this manual explain how one becomes a Nominator or Provider, establish rules and processes for those participating in the DEDP, and provide instructions for completing documentation required by the DEDP.
- **Frequently asked questions** provide an overview of common issues encountered by both Nominators and Providers.
- **Resources for persons with diabetes** are also provided to assist clients with other health care needs, including organizations that may be able to provide eye disease treatment services for which the DEDP does not pay.
- **Lists of participating Nominators and Providers by DSHS Health Service Regions** are provided for use in referring eligible clients for DEDP services.

DIABETIC EYE DISEASE PROGRAM

STATISTICS–2006

Number of Eye Examinations Provided **5,956**

Client Demographics

Sex

Female **4,182**
Male **1,772**
Sex not specified **2**

Race

White **550**
Black **306**
Hispanic **4,969**
Asian **25**
Native American **28**
Other **73**

Age

70 years and older **104**
60-69 years **1,232**
50-59 years **2,466**
40-49 years **1,550**
30-39 years **470**
Less than 30 years **134**

Years since last diagnosis of diabetes

5 years or less since diagnosis **3,126**
More than 5 years since diagnosis **2,830**

Eye Disease (Some exams have more than one condition)

Number of exams with eye disease marked **2,757**
Non-proliferative retinopathy **848**
Proliferative retinopathy **176**
Cataracts **1,560**
Glaucoma **303**
Maculopathy **302**
Other **241**

Eye Treatment (Some exams have more than one condition)

Number of exams with treatment/ FU indicated **5,899**
Treatment / FU indicated for retinopathy **1,099**
Treatment / FU indicated for cataracts . . **1,560**
Treatment / FU indicated for glaucoma . . . **305**
Treatment / FU indicated for maculopathy **303**
Treatment / FU indicated for other **3,394**
Number with referral to Texas Commission for the Blind **2**
Number with referral to other **5,954**

* *Statistics from exams provided between September 1, 2005, and August 31, 2006.*

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GUIDELINES FOR NOMINATORS

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GENERAL INFORMATION

What is the Diabetic Eye Disease Program?

The Diabetic Eye Disease Program (DEDP) provides an initial and annual dilated funduscopic eye examination at no charge. These exams are available to persons with type 1 diabetes who are eighteen years of age or older and all persons with type 2 diabetes who meet established Texas Department of State Health Services (DSHS) income criteria. Client eligibility is assessed and referrals are made by nominators (staff of DSHS health service regions, local health departments, and state and federally supported primary care facilities) to contracted ophthalmologists and optometrists in all regions of the state. Populations with high prevalence of diabetes, such as African Americans and Hispanics, are targeted to receive services under this program.

The Texas Legislature funds the program through appropriations for the Texas Diabetes Council, Texas Department of State Health Services. The program is administered by Texas Diabetes Program/Council staff at DSHS.

BACKGROUND

An estimated **1.3 million** adults in Texas have been **diagnosed** with diabetes. Another **418,134** adults in Texas are estimated to have **undiagnosed** diabetes.[1] Eye complications of diabetes include diabetic retinopathy, cataracts, and glaucoma. Diabetic retinopathy is the most common of these complications. Nationally, diabetes is the leading cause of new cases of blindness in adults 20 to 74 years old. Diabetic retinopathy causes from 12,000 to 24,000 new cases of blindness each year in the U.S.[2]

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[1] *Texas Diabetes Fact Sheet, 2006.* Texas Diabetes Program/Council, Texas Department of State Health Services.

[2] *National Diabetes Fact Sheet, 2005.* American Diabetes Association.

Studies have demonstrated that prompt detection and treatment of proliferative retinopathy can reduce the incidence of severe visual loss by 50 to 60 percent.[3] To detect retinopathy before vision is compromised, annual dilated funduscopic examinations are now recommended for all persons at risk for diabetic eye disease:[4]

- Persons with type 1 diabetes who are eighteen years of age or older and who have had diabetes for five years, or
- All persons with type 2 diabetes regardless of length of time since diagnosis.

Unfortunately, many persons with diabetes are not referred for or assured access to annual eye examinations. Lack of resources is a significant factor contributing to this problem.

PROGRAM DESCRIPTION

A. Purpose of Program: The purpose of the Diabetic Eye Disease Program (DEDP) is to provide dilated funduscopic eye examinations to eligible Texas residents with diabetes so that those with vision-threatening conditions, such as retinopathy, can be identified and referred for treatment.

B. Funding and Administration: The program is supported with funds appropriated by the Texas Legislature for the Texas Diabetes Council, Texas Department of State Health Services (DSHS). Program activities are administered by Texas Diabetes Program/Council staff at DSHS.

C. Program Participants: There are three categories of participants in the Program: eligible patients, program nominators, and eye care providers.

a. Eligible Patients:

Funding for the Diabetic Eye Disease Program is limited. As a result, the program is intended as a resource of **last resort** for low-income individuals who do not have financial access to other sources of care.

Nominators are strongly encouraged to identify and partner with local non-profit organizations and providers to meet the eye care exam and treatment needs of patients with diabetes.

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[3] *Diabetes In America, 2nd edition, 1995.* National Diabetes Data Group. National Institutes of Health. National Institute of Diabetes and Digestive and Kidney Diseases. NIH Publication No. 95–1468

[4] *Diabetes Mellitus Minimum Practice Recommendations Flow Sheet.* Texas Diabetes Council, Texas Department of State Health Services.

Eligible patients are persons who:

- Meet the program definition of being at risk for diabetic eye disease (i.e., persons with type 1 diabetes who have had diabetes for five or more years or any person with type 2 diabetes, regardless of when they were diagnosed);
- Are not currently eligible for eye examinations from any other third party payor, such as Medicare, Medicaid, or private health insurance;
- Are a resident of Texas (proof of residence may include voter registration card, rent/mortgage receipt, mortgage company, utility bill/receipt/records, official records of ownership of property, employer, Texas Motor Vehicle Commission (DMV), school or day care records, child care provider, home visit, DPS ID, non-relative, post office records, mail received with name and address, telephone directory, city or crisscross directory, church or baptismal record, Texas driver's license (valid), VolAg Form 1857 Landlord Verification); **AND**
- Meet the income criteria established by the Texas Department of State Health Services as described in the Department's Guidelines for Clinical Health Services. Please note that these criteria now limit total family income to at or below **150 percent** of the Federal Poverty Level (FPL). Federal Poverty Guidelines, based on family size, are found in Section 3, page 9. There are no asset considerations or other paperwork requirements.

b. Program Nominators:

Staff of DSHS health service regions, local health departments, and state and federally supported primary care facilities serve as nominators. Nominators play a key role in the program by:

- assessing client eligibility;
- referring clients to eye care providers;
- following up with clients and providers to assure that appointments are met;
- assisting clients, when indicated, in accessing and obtaining additional follow-up services and/or treatment;
- and tracking patients who are referred for follow-up services and determining whether and where these services are obtained (See Sample Tracking Form Section 3, page 7, for instructions on how to indicate referral).

NOTE: Follow-up care is not funded by this or any other program administered by the Texas Diabetes Program/Council.

A unique, identifying nominator number is assigned to the facility where program nominators are employed. However, all people within a facility who act as nominators must be individually registered with the Texas Diabetes Program/Council.

Only registered nominators may refer clients with diabetes to eye care providers. Nominators are not authorized to transfer blank Patient Tracking Forms for use by other individuals within a facility. Tracking forms signed by individuals who are not nominators registered with the Texas Diabetes Program/Council are considered invalid and are considered ineligible for payment.

To enroll as a nominator, contact the Texas Diabetes Program/Council using the contact information at the end of this section. A Nominator Application must also be submitted (See Section 3, page 1).

c. Eye Care Providers:

Ophthalmologists and optometrists are contracted by DSHS to perform eye examinations for eligible clients referred by nominators. To participate, providers must have a current Texas license to practice medicine or optometry and must be in good standing with the Texas Board of Medical Examiners or Texas Board of Optometry, whichever is applicable. **Providers are not permitted to also serve as nominators for the DEDP.** Lists of providers by region are available to nominators on request (See List of Providers, Section 8). For more detailed information about providers, please refer to the Guidelines for Providers of Service (Section 4).

To enroll as an eye care provider for the program, please contact the Diabetes Program/Council staff using the contact information at the end of this section.

Scope of Services: Providers are contracted by DSHS to perform an ophthalmoscopic examination of the fundus through dilated pupils. The examination will also include the following:

- Blood Pressure Measurement
- History of Visual Symptoms

- Visual Acuity Uncorrected / Best Corrected
- Assessment of Visual Field, Muscle Function & Lens Opacity
- Measurement of Intraocular Pressure
- Eye Pathology Classification
- Recommendations

Funding Limitations: Providers are reimbursed **$60** for each eye examination. Funds are not available for any diagnostic tests such as fluorescein angiography or for treatment procedures or medications. **PAYMENT WILL NOT BE MADE FOR ANY DIAGNOSTIC TESTS OR TREATMENT OF EYE DISEASE.** Nominators are encouraged to assist clients in obtaining other sources of payment for diagnostic and treatment services.

Allowable Benefits: Benefits per client per year (any 12 month period) are limited to one annual screening examination. In instances where eye disease (retinopathy, maculopathy) is detected in the initial exam, **two additional follow-up exams may be administered if needed.** Total payments are not to exceed **$180** for three exams per client per year.

PROGRAM OPERATION

A. Patient Tracking Form: A Texas Diabetes Program Patient Tracking Form (Section3, page 5) is used to document client eligibility, referral, examination, and follow-up data. It is also used by providers to claim payment for services. Each form has a unique number that serves as a key reference throughout the referral, examination, and payment process.

B. Routing a Patient Tracking Form: The form is a single page document with two carbon copy sheets. Each sheet is a different color to designate which copy should be retained by the nominator, provider, and Texas Diabetes Program, DSHS. Nominators initiate a Patient Tracking Form each time they refer a client to an eye care provider.

Routing of the form is as follows:

- **Nominator –** Completes client/nominator information on form. The WHITE and CANARY copies are forwarded to the Provider. The PINK copy should be retained by the nominator for files and referral follow-up purposes.

- **Provider –** Records examination information, signs, and submits the WHITE COPY to the Texas Diabetes Program for reimbursement. The CANARY copy should be retained by the provider for files.

C. Obtaining Patient Tracking Forms: Patient Tracking Forms are supplied to program nominators. Nominators may obtain forms by completing a Request for Tracking Forms (Section 3, page 3) and submitting it to the Texas Diabetes Program/Council.

D. Accountability: Nominators are accountable for the Patient Tracking Forms they receive. They should maintain a file copy of initiated forms (PINK COPY).

E. Client Referral: The nominator first determines client eligibility based on program criteria. If eligible, the nominator completes the applicant and nominator sections of a Patient Tracking Form. (See Sample Tracking Form – Section 3, page 7).

The nominator assists the client in obtaining an appointment for an eye examination with a participating provider. In areas where there is more than one participating provider, it may be desirable to rotate client referrals among providers. However, clients may also choose their preference from among the listed participating providers in their area. Lists of participating providers may be obtained by contacting the Texas Diabetes Program/Council, Texas Department of State Health Services. Use of non-participating providers is not authorized and non-participating providers will **not be paid** for services rendered.

F. Client Tracking and Follow-up: Nominators are responsible for tracking clients referred to confirm that appointments are being kept. It is suggested that nominators develop an ongoing line of communication with local providers to minimize referral problems and delays in scheduling exams. Anyone in the office can be designated to carry out follow-up responsibilities.

G. Inquiries and Requests: All inquiries and requests regarding the Diabetic Eye Disease Program should be directed to:

Texas Diabetes Program
Texas Department of State Health Services
1100 W. 49th Street,
Austin, TX 78756-3199

Phone: (512) 458-7111 ext. 7490
Toll free: 1-888-963-7111 ext. 7490
Fax: (512) 458-7408
Website: www.texasdiabetescouncil.org

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Instructions and Forms

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TEXAS DIABETES COUNCIL

NOMINATOR APPLICATION

NOMINATOR APPLICATION: #_____

Please Print

Name: _____
Last First Middle

Title: _____

Facility/Clinic: _____

Address: _____
Number, Street or P.O. Box

_____
City State Zip

Telephone: (_____) _____ **Fax:** (_____) _____

E-Mail: _____

County: _____ **TDH Region:** _____

Estimated number of clients to be referred by you for an Eye Exam within the next 12 months: _____

Sign below to confirm that you have read and understand the information in the nominator applications guidelines:

Signature: _____ **Date:** _____

Mail To:
Texas Diabetes Program/Council
Texas Department of State Health Services
1100 W. 49th Street
Austin, Texas 78756-3199

Note: Please call (512) 458-7111 ext. 7490 for assistance or questions.

TEXAS Department of State Health Services

DIABETIC EYE DISEASE PROGRAM

TEXAS DIABETES COUNCIL

REQUEST FOR TRACKING FORMS

Please type or print the information requested on this form.
Include full mailing address on the bottom of this request.

Date of this Request: _____

DSHS Region Number: _____

Nominator Name: _____

Facility/Clinic Name: _____

Nominator ID Number: _____

Nominator E-mail Address: _____ **Telephone: (____)** _____

Number of Forms Received on Last Request: _____

Date of last request: _____

Number of Forms Initiated Since Last Request: _____

Number of Forms on Hand at this Time: _____

Number of Forms Requested: _____

Mailing Address: _____

_____

Signature: _____

Note: Please call toll free (888)963-7111 ext. 7490

Return To: Diabetic Eye Disease Program
Texas Diabetes Program/Council
Texas Department of State Health Services
1100 W. 49th Street
Austin, Texas 78756-3199

TEXAS Department of State Health Services

DIABETIC EYE DISEASE PROGRAM

TEXAS DIABETES COUNCIL

TEXAS Department of State Health Services

FORM#

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

PATIENT TRACKING FORM

DIABETIC EYE DISEASE PROGRAM
TEXAS DIABETES PROGRAM

[Note: Please type or print clearly. Forms with incomplete or illegible information will be returned and payment will be delayed.]

APPLICANT'S NAME SS# DATE OF BIRTH

ADDRESS CITY ZIP COUNTY

SEX (M or F) AGE RACE/ETHNICITY (Circle one): White Black Hispanic Native American Asian Other

YEAR DIAGNOSED WITH DIABETES TYPE OF DIABETES (Type 1 or Type 2)

APPLICANT MUST SIGN

I hereby certify that I am a resident of Texas, my family income is at or below 150% of the federal poverty level, and I have no source of public or private health insurance to provide for the eye care services needed and herein requested. Privacy notification attached.

Signature Date

TO BE COMPLETED BY NOMINATOR

Nominator ID# Facility/Organization

Month/year of applicant's last dilated eye exam Date ________ Last A_1C Result ______% Blood Pressure _____/_____

Does applicant have access to dilated funduscopic eye examinations from Medicare, Medicaid, Private Health Insurance, or any other source of public or private health insurance? Yes No (If yes, indicate source)

Is applicant's family's income at or below 150% of the federal poverty level? Yes No

Is applicant a resident of the state of Texas? Yes No

[Note: If the answer to the first question is "yes" and to the following two questions is "no", then the individual is not eligible for services.]

I hereby nominate the above-named person as meeting the criteria for participation in the Diabetic Eye Disease Program.

Name/Title Address City Zip County

( ) DSHS Region #

Signature Date Phone Number

TO BE COMPLETED BY PROVIDER

DATE CLIENT SEEN / /

VISUAL ACUITY Uncorrected O.D. 20/ O.S. 20/ Best Corrected O.D. 20/ O.S. 20/

If unable to measure, estimate visual function: ( ) Legally Blind ( ) Not Legally Blind

VISUAL FIELD	MUSCLE FUNCTION	LENS OPACITY	INTRAOCULAR PRESSURE
( ) No Restriction	( ) Normal	( ) Normal	O.D.
( ) Restriction	( ) Abnormal	( ) Abnormal	O.S.

EYE PATHOLOGY	( ) Nonproliferative Retinopathy	( ) Proliferative Retinopathy	( ) Diabetic Maculopathy
	( ) Glaucoma	( ) Cataracts	( ) No Pathology

RECOMMENDATIONS (Check all that apply)

( ) Treatment NOT indicated Next Ophthalmic Exam: month year

( ) Treatment Indicated For: ( ) Retinopathy ( ) Glaucoma ( ) Cataracts ( ) Maculopathy

( ) Referral to Commission for the Blind ( ) Referral to other specialty

COMMENTS

PROVIDER'S NAME PAYEE ID#

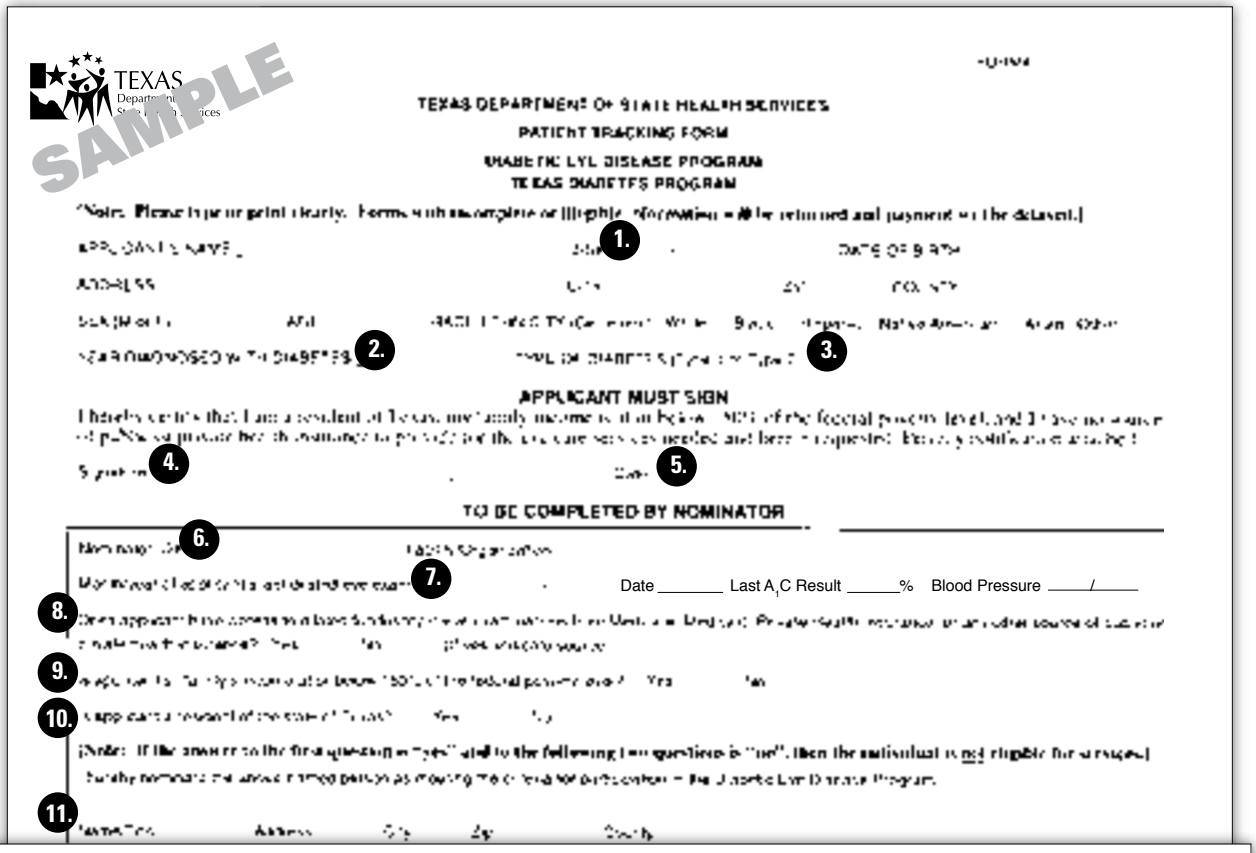
CLINIC NAME

ADDRESS CITY ZIP

Signature Date / PHONE# ( )

White copy: Program office, Texas Diabetes Program, DSHS, 1100 West 49th Street, Austin, Texas ... Send with bill for payment
Canary copy: Provider retains for files. Pink copy: Nominator retains for files and follow-up after exam is completed. Form ... 12/2006

SAMPLE TRACKING FORM



1. Enter applicant's social security number. If applicant does not have a social security number, leave blank.

2. Year diagnosed with diabetes is required to determine applicant's eligibility to receive services. Eligible applications are persons with type 1 diabetes who have had diabetes for five or more years or any persons with type 2 diabetes, regardless of when they were diagnosed.

3. Indicate whether the applicant has type 1 or type 2 diabetes to determine eligibility (see #2).

4. Signature of applicant must be obtained on the date of referral to a provider.

5. Patient Tracking Form should be signed by the applicant and the nominator on the same date, signifying that the nominator and applicant have discussed services provided by the DEDP and eligibility criteria, and the client has received a copy of the DSHS Privacy Policy.

6. Nominators are assigned an ID number when they are approved to participate in the DEDP by the Texas Department of State Health Services. If unsure of your ID number, refer to correspondence received from DSHS when your Nominator Application was approved, refer to the listing of Nominators in the back of this manual or contact the Diabetes Program at (512) 458-7490.

Turn Over for Additional Instructions.

Additional Instructions for Sample Tracking Form

7. Poor lab results can be indicative of risk for diabetic eye disease. This information is needed for provider assessment of patient's eye health.

8. Be sure to completely answer questions related to patient's eligibility for DEDP services. The DEDP will contact nominators to verify the patient's eligibility status if ALL questions are not answered. Evacuees from other states who are currently living in Texas and meet DEDP eligibility criteria can receive DEDP services.

9. Paycheck stubs may be used to determine if client meets income requirement of at or below 150% of the federal poverty level. Determine monthly income by looking at four pay stubs if paid each week, two if paid twice a month, etc. A paycheck stub can also be used to determine residence. See next page for poverty level guidelines.

10. Proof of residency may consist of a Texas ID or driver's license, rent/mortgage receipt, or utility bill. For additional information, see the description of eligible patients found in the Guidelines for nominators (Section 2, page 2).

11. Clearly print the nominator's name, work/facility address, county and phone number, then sign and date. Be sure to include the DSHS Health Service Region number, which can be determined using the maps included with the nominator and provider listings in the back of this manual.

FEDERAL POVERTY GUIDELINES

2007 POVERTY LEVEL GUIDELINES
ALL STATES (EXCEPT ALASKA AND HAWAII) AND DC
Income Guidelines as Published in the Federal Register on January 24, 2007

ANNUAL GUIDELINES

FAMILY SIZE	100% POVERTY*	120%	133%	150%	170%	175%	185%	190%	200%	250%	300%	400%
1	10,210.00	12,252.00	13,579.30	15,315.00	17,357.00	17,867.50	18,888.50	19,399.00	20,420.00	25,525.00	30,630.00	40,840.00
2	13,690.00	16,428.00	18,207.70	20,535.00	23,273.00	23,957.50	25,326.50	26,011.00	27,380.00	34,225.00	41,070.00	54,760.00
3	17,170.00	20,604.00	22,836.10	25,755.00	29,189.00	30,047.50	31,764.50	32,623.00	34,340.00	42,925.00	51,510.00	68,680.00
4	20,650.00	24,780.00	27,464.50	30,975.00	35,105.00	36,137.50	38,202.50	39,235.00	41,300.00	51,625.00	61,950.00	82,600.00
5	24,130.00	28,956.00	32,092.90	36,195.00	41,021.00	42,227.50	44,640.50	45,847.00	48,260.00	60,325.00	72,390.00	96,520.00
6	27,610.00	33,132.00	36,721.30	41,415.00	46,937.00	48,317.50	51,078.50	52,459.00	55,220.00	69,025.00	82,830.00	110,440.00
7	31,090.00	37,308.00	41,349.70	46,635.00	52,853.00	54,407.50	57,516.50	59,071.00	62,180.00	77,725.00	93,270.00	124,360.00
8	34,570.00	41,484.00	45,978.10	51,855.00	58,769.00	60,497.50	63,954.50	65,683.00	69,140.00	86,425.00	103,710.00	138,280.00

*For family units of more than 8 members, add $3,480

MONTHLY GUIDELINES

FAMILY SIZE	100% POVERTY	120%	133%	150%	170%	175%	185%	190%	200%	250%	300%	400%
1	850.83	1,021.00	1,131.61	1,276.25	1,446.42	1,488.96	1,574.04	1,616.58	1,701.67	2,127.08	2,552.50	3,403.33
2	1,140.83	1,369.00	1,517.31	1,711.25	1,939.42	1,996.46	2,110.54	2,167.58	2,281.67	2,852.08	3,422.50	4,563.33
3	1,430.83	1,717.00	1,903.01	2,146.25	2,432.42	2,503.96	2,647.04	2,718.58	2,861.67	3,577.08	4,292.50	5,723.33
4	1,720.83	2,065.00	2,288.71	2,581.25	2,925.42	3,011.46	3,183.54	3,269.58	3,441.67	4,302.08	5,162.50	6,883.33
5	2,010.83	2,413.00	2,674.41	3,016.25	3,418.42	3,518.96	3,720.04	3,820.58	4,021.67	5,027.08	6,032.50	8,043.33
6	2,300.83	2,761.00	3,060.11	3,451.25	3,911.42	4,026.46	4,256.54	4,371.58	4,601.67	5,752.08	6,902.50	9,203.33
7	2,590.83	3,109.00	3,445.81	3,886.25	4,404.42	4,533.96	4,793.04	4,922.58	5,181.67	6,477.08	7,772.50	10,363.33
8	2,880.83	3,457.00	3,831.51	4,321.25	4,897.42	5,041.46	5,329.54	5,473.58	5,761.67	7,202.08	8,642.50	11,523.33

PRIVACY NOTIFICATION / NOTIFICACIÓN SOBRE PRIVACIDAD

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See www.tdh.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 522.021, 522.023 and 559.004)

Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a www.tdh.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 522.021, 522.023 y 559.004)

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stock #OGC-1 September 2004

TEXAS Department of State Health Services

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GENERAL INFORMATION

What is the Diabetic Eye Disease Program?

The Diabetic Eye Disease Program (DEDP) provides an initial and annual dilated funduscopic eye examination at no charge. These exams are available to persons with type 1 diabetes who are eighteen years of age or older and all persons with type 2 diabetes who meet established Texas Department of State Health Services (DSHS) income criteria. Client eligibility is assessed and referrals are made by nominators (staff of DSHS health service regions, local health departments, and state and federally supported primary care facilities) to contracted ophthalmologists and optometrists in all regions of the state. Populations with high prevalence of diabetes, such as African Americans and Hispanics, are targeted to receive services under this program.

The Texas Legislature funds the program through appropriations for the Texas Diabetes Council, Texas Department of State Health Services. The program is administered by Texas Diabetes Program/Council staff at DSHS.

BACKGROUND

An estimated 1.3 million adults in Texas have been diagnosed with diabetes. Another 418,134 adults in Texas are estimated to have undiagnosed diabetes.[1] Eye complications of diabetes include diabetic retinopathy, cataracts, and glaucoma. Diabetic retinopathy is the most common of these complications. Nationally, diabetes is the leading cause of new cases of blindness in adults 20 to 74 years old. Diabetic retinopathy causes from 12,000 to 24,000 new cases of blindness each year in the U.S.[2]

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[1] *Texas Diabetes Fact Sheet, 2006.* Texas Diabetes Program/Council, Texas Department of State Health Services.

[2] *National Diabetes Fact Sheet, 2005.* American Diabetes Association.

Studies have demonstrated that prompt detection and treatment of proliferative retinopathy can reduce the incidence of severe visual loss by 50 to 60 percent.[3] To detect retinopathy before vision is compromised, annual dilated funduscopic examinations are now recommended for all persons at risk for diabetic eye disease:[4]

- Persons with type 1 diabetes who are eighteen years of age or older and who have had diabetes for five years;
- or all persons with type 2 diabetes regardless of length of time since diagnosis.

Unfortunately, many persons with diabetes are not referred for or assured access to annual eye examinations. Lack of resources is a significant factor contributing to this problem.

PURPOSE OF PROGRAM

The purpose of the Diabetic Eye Disease Program (DEDP) is to provide dilated funduscopic eye examinations to eligible Texas residents with diabetes so that those with vision-threatening conditions, such as retinopathy, can be identified and referred for treatment.

PARTICIPATING PROVIDERS

Persons providing services under the DEDP must have a current Texas license to practice medicine or optometry and must be in good standing with the Texas Board of Medical Examiners or Texas Board of Optometry, whichever is applicable. Persons wishing to be providers should furnish the information requested on the "Agreement Between Eye Care Provider and Texas Department of State Health Services" (Section 5, page 1) and return the completed contract to the Texas Diabetes Program/Council, Texas Department of State Health Services, 1100 West 49th Street, Austin, TX 78756-3199.

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[3] *Diabetes In America, 2nd edition, 1995.* National Diabetes Data Group. National Institutes of Health. National Institute of Diabetes and Digestive and Kidney Diseases. NIH Publication No. 95–1468

[4] *Diabetes Mellitus Minimum Practice Recommendations Flow Sheet.* Texas Diabetes Council, Texas Department of State Health Services.

CIVIL RIGHTS

Diabetic Eye Disease Program providers of services are subject to provisions of the Federal Civil Rights Act of 1964, Public Law 88-532, and Texas Civil Statutes, Article 6252-16, so that no person will be excluded from participation in the DEDP, or otherwise subjected to discrimination on the grounds of race, color, or national origin.

PATIENT ELIGIBILITY

Eligible persons include individuals with diabetes who (1) meet the program criteria (i.e., are at high risk for developing diabetic eye disease as described under "Background"), (2) are not covered for eye exams from any other third party payor (i.e., Medicare, Medicaid or private insurance), (3) are residents of Texas, and (4) meet the income criteria established by the Texas Department of State Health Services as described in the Department's Guidelines for Clinical Health Services. Income criteria for public health services is 150 percent of poverty or below. (See Federal Poverty Guidelines, Section 3, page 7).

NOMINATORS AND AREA CLIENT REFERRALS

Individuals must be referred to the provider by staff of DSHS regions, local health departments, community clinics, or others who have been designated to serve as nominators. The nominator's responsibility is to assess whether a prospective client with diabetes meets program eligibility criteria and to refer eligible clients to a provider. Nominators also assist in follow-up with clients and providers regarding missed appointments and the need for subsequent treatment for eye disease.

PROVIDERS AND AREA CLIENT REFERRALS

A tracking form is used to document patient referral, examination, treatment and/or follow up for treatment information. The form also serves as a mechanism by which the provider claims payment for services provided. (See Sample Tracking Form, Section 5, page7.)

PROGRAM SERVICES AND BENEFITS

A. Scope of Services: The examination will be an ophthalmoscopic examination of the fundus through dilated pupils and will also include:

- Blood Pressure Measurement
- History of Visual Symptoms
- Visual Acuity, Uncorrected/Best Corrected
- Assessment of Visual Field, Muscle Function & Lens Opacity
- Measurement of Intraocular Pressure
- Eye Pathology Classification
- Recommendations

B. Reimbursement and Funding Limitations. Providers will be reimbursed $60 for each eye examination. Funds are not available for any diagnostic tests such as fluorescein angiography, nor are funds available for treatment procedures. **THEREFORE, PAYMENT WILL NOT BE MADE FOR DIAGNOSTIC TESTS OR FOR TREATMENT OF EYE DISEASE.**

C. Benefits. Maximum allowable benefits per patient per year are limited to one annual screening examination. In instances where eye disease (retinopathy, maculopathy) is detected in the initial exam, two additional follow-up exams may be administered if needed. Total benefits are not to exceed $180 per patient per year [a given 12 month period], unless written approval is obtained from the Diabetic Eye Disease Program.

PAYMENT FOR SERVICES

A. Payee Identification Number: To receive payment for services, providers must have a State of Texas payee identification number. Diabetes Program/Council staff will assist providers who do not have a number in obtaining one at the time a fee-for-service contract is processed.

B. Filing Payment Claims. The Patient Tracking Form serves as the provider's bill for services. Each form has a unique identification number in the upper right hand corner. This number is used as sole identifier for processing claims and payments. A nominator, when referring a client, will forward a Patient Tracking Form to the provider containing relevant client/nominator information. The provider completes the physician or optometrist section of the form by noting findings, recommendations, name, address, telephone number, and payee identification number. The form is then signed by the provider. **To ensure timely payment**, all information requested from the ophthalmologist and optometrist must be included on the form.

Upon completion of the client's eye examination, the signed Tracking Form should be routed as follows:

The **WHITE COPY** is to be sent to the following address:

Diabetic Eye Disease Program
Texas Diabetes Program/Council
Texas Department of State Health Services
1100 W. 49TH Street,
Austin, TX 78756-3199

Once received in Austin, the claim will be processed and payment made.

The provider records examination information, signs, and submits the **WHITE COPY** to the Texas Diabetes Program/Council for payment. The **CANARY COPY** is retained by the provider for office files.

NOTE: Payments issued by the State to the provider will not list the client's name. Therefore, we suggest that provider offices maintain a separate file of Canary Copies or a listing of form numbers and the corresponding client names for persons examined. Using this method, the Tracking Form number listed on a payment received can be matched with the individual client who received the examination.

Providers will be paid for providing only approved services (approved services are those services listed in Section 4, page 4, Scope of Services). Payment for approved services can only be made after delivery of the service. **PRIVATE PROVIDERS MUST AGREE TO ACCEPT PROGRAM FEES AS PAYMENT IN FULL FOR THE SERVICE PROVIDED, ALTHOUGH SUCH FEES MAY BE LOWER THAN USUAL AND CUSTOMARY CHARGES.**

Payments for claims will be made no later than 60 days after receipt of the Tracking Form from the provider. Payment is considered made on the date postmarked.

In the event of errors on the Patient Tracking Form, Texas Diabetes Program/Council staff will contact the provider with an explanation of any corrections that are necessary.

ALL INQUIRIES REGARDING CLAIMS FOR PAYMENT MAY BE MADE IN WRITING TO THE TEXAS DIABETES PROGRAM/COUNCIL OR BY TELEPHONE CONTACT AT (512) 458-7111 EXTENSION 2833. PLEASE HAVE THE TRACKING FORM IDENTIFICATION NUMBER AVAILABLE WHEN MAKING A CLAIM INQUIRY.

C. Denial of Claims. Payment for eye examinations will not be made under the following circumstances:

- Client does not meet eligibility requirements of the DEDP;
- Client is not a resident of Texas;
- Services provided were not specifically covered by the DEDP;
- Patient failed to appear for treatment and no service was rendered (no-shows);
- Claim for the same eye examination was previously paid by the DEDP (duplicate claim).

D. Reconsideration of Denied Claims. A claim that has been denied in error by the DEDP will be reconsidered for payment if:

- The original claim with the error identified and corrected is returned to the Diabetes Program within 30 days from receipt of the notice of denial;
- The claim is accompanied by a copy of the DEDP notice of denial.

E. Claims Exceeding Time Limit. The eye examination should be completed and the signed Patient Tracking Form received by the DEDP **within 75 days of initiation of the form by the nominator**. If special or extenuating circumstances exist which make it impossible or impractical for the provider to complete services within the time period, such claims will be evaluated by the Section Director of the Disease Prevention and Intervention Section (Texas Department of State Health Services) on an individual basis, with due consideration given to the circumstances.

F. Due Process Hearing. In the event the provider contract is terminated or suspended, or any claim for payment is denied following reconsideration, the provider will be afforded an opportunity for a due process hearing. The provider must request such hearing **in writing** to the Section Director of the Disease Prevention and Intervention Section, Texas Department of State Health Services, 1100 West 49th Street, Austin, TX 78756-3199, within 10 days of the provider's receipt of notice of termination, suspension, or denial of claim for payment.

DIABETIC EYE DISEASE PROGRAM

GUIDELINES FOR PROVIDERS

Instructions and Forms

TEXAS Department of State Health Services

DIABETIC EYE DISEASE PROGRAM

TEXAS DIABETES COUNCIL

TEXAS Department of State Health Services

AGREEMENT BETWEEN EYE CARE PROVIDER AND TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Please Print or Type

Name of Provider: _____

If an individual, insert Last Name followed by First Name and Middle Initial. If not an individual or sole proprietor, insert full name of corporation, partnership or professional association.

This agreement is made and entered on this the _____ (Day) of _____ (Month), 200___ (Year) by and between the Texas Department of State Health Services (TDSHS) and the Provider named above.

I. THE PROVIDER AGREES:

1. To provide eye care services as authorized by TDSHS to eligible recipients in accordance with reimbursement policies and operational instructions established for the program as set forth in the Texas Department of State Health Services, Diabetic Eye Disease Program Manual for Providers of Services, which is hereby incorporated into, and made a part of this contract by reference. Changes in or amendments to this manual which may be added from time to time during the life of this contract constitute amendments to this contract. Such changes will be forwarded by TDSHS to the Provider.

2. To accept payment under this contract as payment in full for the services rendered under this contract, except as provided for in paragraph #3.

3. To seek payment for services authorized under this contract from any third party insurance coverage the recipient might have before seeking payment under this contract.

4. To not make charges to the recipient except for additional services desired by the recipient which are not authorized under this contract.

5. To personally certify any claim for payment.

6. To treat each recipient with the same respect and consideration as any other patient and to provide services without regard to age, race, color, national origin or handicap.

7. To comply with a) Article 4495b, V.T.C.S. (Texas Medical Practice Act), and applicable rules and regulations adopted by the Texas Board of Medical Examiners; for b) Article 4552 V.T.C.S. (Texas Optometry Act), and applicable rules and regulations adopted by the Texas Optometry Board.

8. To submit to the jurisdiction and decision of the legally constituted Peer Review or Grievance Committee serving the area of my practice, if requested by TDSHS or Provider's licensing agency.

9. To accord access to all records related to services rendered or to be rendered under this contract for examination or copying at any reasonable time to representatives of TDSHS.

10. To allow authorized representatives of the state government to evaluate through inspection or other means the quality, appropriateness, extent, and timeliness of services rendered or to be rendered under this contract.

11. To maintain and retain for a period of three years from the date of submittal of the claim for payment, or until all audit questions are resolved, whichever time is longer, any and all records to property reflect performance under this contract.

12. To establish a system to safeguard the confidentiality of recipient records and information.

13. To notify TDSHS promptly of any changes in my office mailing address or telephone number.

14. To supply promptly all information requested by TDSHS for payment of outstanding claims if this contract is terminated or suspended.

15. To immediately cease providing services and notify TDSHS if Provider's license is suspended, probated, or terminated by the Texas Board of Medical Examiners or Texas Optometry Board.

16. To certify by execution of this contract that Provider's payment of franchise taxes is current or, if Provider is exempt from payment of franchise taxes, that Provider is not subject to the State of Texas franchise taxes. A false statement regarding franchise tax status will be treated as material breach of this contract and may be grounds for termination at the option of TDSHS. If franchise tax payments become delinquent during the contract term, payment under this contract will be held until Provider's delinquent franchise tax is paid in full.

17. To further certify by execution of this contract that Provider is not ineligible for participation in federal or state assistance programs under Executive Order 12549, Department and Suspension. Provider specifically asserts that Provider does not owe a single substantial debt or a number of outstanding debts to a federal or state agency. A false statement regarding Provider's status will be treated as a material breach of this contract and may be grounds for termination at the option of TDSHS.

II. TDSHS AGREES:

1. To reimburse the Provider for services properly rendered in accordance with applicable laws, regulations, operational instructions and this contract. Payments made for approved claims or notice of denial of claims submitted against this contract will be mailed not later than 60 days after receipt of monthly vouchers. Payment is considered made on the date postmarked.

2. To promptly notify the Provider of any change in operational instructions.

3. In the event of its intention to suspend or terminate this contract, or to deny payment of any claim hereunder, TDSHS will afford the Provider an opportunity of a due process hearing in accordance with the Manual For Providers of Services.

III. TDSHS AND THE PROVIDER MUTUALLY AGREE:

1. That participation in the program is voluntary.

2. That this contract is subject to the availability of funds and is not transferable or assignable.

3. That this contract is contingent upon funding being available for the term of the contract and Provider will have no right of action against the DEPARTMENT in the event that Provider is unable to perform its obligations under this contract as a result of the suspension, termination, withdrawal, or failure of funding to the DEPARTMENT or lack of sufficient funding of PROVIDER for the contract. If funds become unavailable, termination provisions of this contract will apply.

4. That in the event State laws or other requirements are amended or judicially interpreted so as to render the fulfillment of this contract on the part of either party unfeasible or impossible, or if the parties to this

contract are unable to agree on modifying amendments necessary for its substantial continuation, then both TDSHS and the Provider will be discharged from further obligation created under this contract. The contract termination will be subject to the equitable settlement of the respective accrued interests up to the date of termination.

5. That if the Provider is suspended, placed on probation, or if his/her its license is revoked by the Texas Board of Medical Examiners or the Texas Optometry Board, this contract will be void as of the date of such action.

6. That this contract can be terminated by either party by the giving of thirty days notice in writing to the other party.

7. That this contract also can be terminated by either party for breach of contract. Such termination shall be effective upon receipt by the other party of written notice of termination, or upon any later date specified therein.

8. That this contract may be amended by the consent of the parties hereto. Each amendment must be in writing and is not effective until it is signed by both parties.

9. That the term of this contract will begin on the date of full and complete execution by both parties hereto and will continue in force until it is terminated by either party.

Provider

Signature

If not an individual or sole proprietor, signature must be by a person authorized to legally sign for the corporation, partnership, or professional organization.

Name (print or type)

Date

Texas Department of State Health Services

By

Philip Huang, M.D., M.P.H.
Medical Director, Chronic Disease Prevention

Date

Office Address:

Street City State Zip

( )
Telephone

Texas Medical License Number

Texas Optometric License Number

Please enter your taxpayer identification number in the appropriate space below. For individuals and sole proprietors, this is your social security number. For other entities, it is your federal employer's identification number.

Social Security Number

Federal Employer's Identification Number

Texas Charter Number

Check Appropriate Ownership Code

❑ Individual recipient (not owning a business)
❑ Texas Corporation
❑ Sole Ownership
❑ Professional Association
❑ Partnership
❑ Professional Corporation

Mail To:
Texas Diabetes Program/Council
Texas Department of State Health Services
1100 W. 49th Street
Austin, Texas 78756-3199

TEXAS Department of State Health Services

TEXAS DIABETES COUNCIL

TEXAS Department of State Health Services

FORM [illegible]

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

PATIENT TRACKING FORM

DIABETIC EYE DISEASE PROGRAM
TEXAS DIABETES PROGRAM

[Note: Please type or print clearly. Forms with incomplete or illegible information will be returned and payment will be delayed.]

APPLICANT'S NAME SS# DATE OF BIRTH

ADDRESS CITY ZIP COUNTY

SEX (M or F) AGE RACE/ETHNICITY (Circle one) White Black Hispanic Native American Asian Other

YEAR DIAGNOSED WITH DIABETES TYPE OF DIABETES (Type 1 or Type 2)

APPLICANT MUST SIGN

I hereby certify that I am a resident of Texas, my family income is at or below 150% of the federal poverty level, and I have no source of public or private health insurance to pay for the eye care services needed and herein requested. Privacy notification attached.

Signature Date

TO BE COMPLETED BY NOMINATOR

Nominator ID# Facility/Organization

Month/year of applicant's last dilated eye exam Date ________ Last A_1C Result ______% Blood Pressure ____/_____

Does applicant have access to dilated funduscopic eye examinations from Medicare, Medicaid, Private Health Insurance, or any other source of public or private health insurance? Yes No (If yes, indicate source)

Is applicant's family's income at or below 150% of the federal poverty level? Yes No

Is applicant a resident of the state of Texas? Yes No

[Note: If the answer to the first question is "yes" and to the following two questions is "no", then the individual is not eligible for services.]

I hereby nominate the above-named person as meeting the criteria for participation in the Diabetic Eye Disease Program.

Name/Title Address City Zip County

( ) DSHS Region #

Signature Date Phone Number

TO BE COMPLETED BY PROVIDER

DATE CLIENT SEEN / /

VISUAL ACUITY Uncorrected: O.D. 20/ O.S. 20/ Best Corrected: O.D. 20/ O.S. 20/

If unable to measure, estimate visual function: ( ) Legally Blind ( ) Not Legally Blind

VISUAL FIELD	MUSCLE FUNCTION	LENS OPACITY	INTRAOCULAR PRESSURE
( ) No Restriction	( ) Normal	( ) Normal	O.D.
( ) Restriction	( ) Abnormal	( ) Abnormal	O.S.

EYE PATHOLOGY ( ) Nonproliferative Retinopathy ( ) Proliferative Retinopathy ( ) Diabetic Maculopathy
( ) Glaucoma ( ) Cataracts ( ) No Pathology

RECOMMENDATIONS (Check all that apply)

( ) Treatment NOT Indicated Next Ophthalmic Exam month year

( ) Treatment Indicated For: ( ) Retinopathy ( ) Glaucoma ( ) Cataracts ( ) Maculopathy

( ) Referral to Commission for the Blind ( ) Referral to other specialty

COMMENTS

PROVIDER'S NAME PAYEE ID#

CLINIC NAME

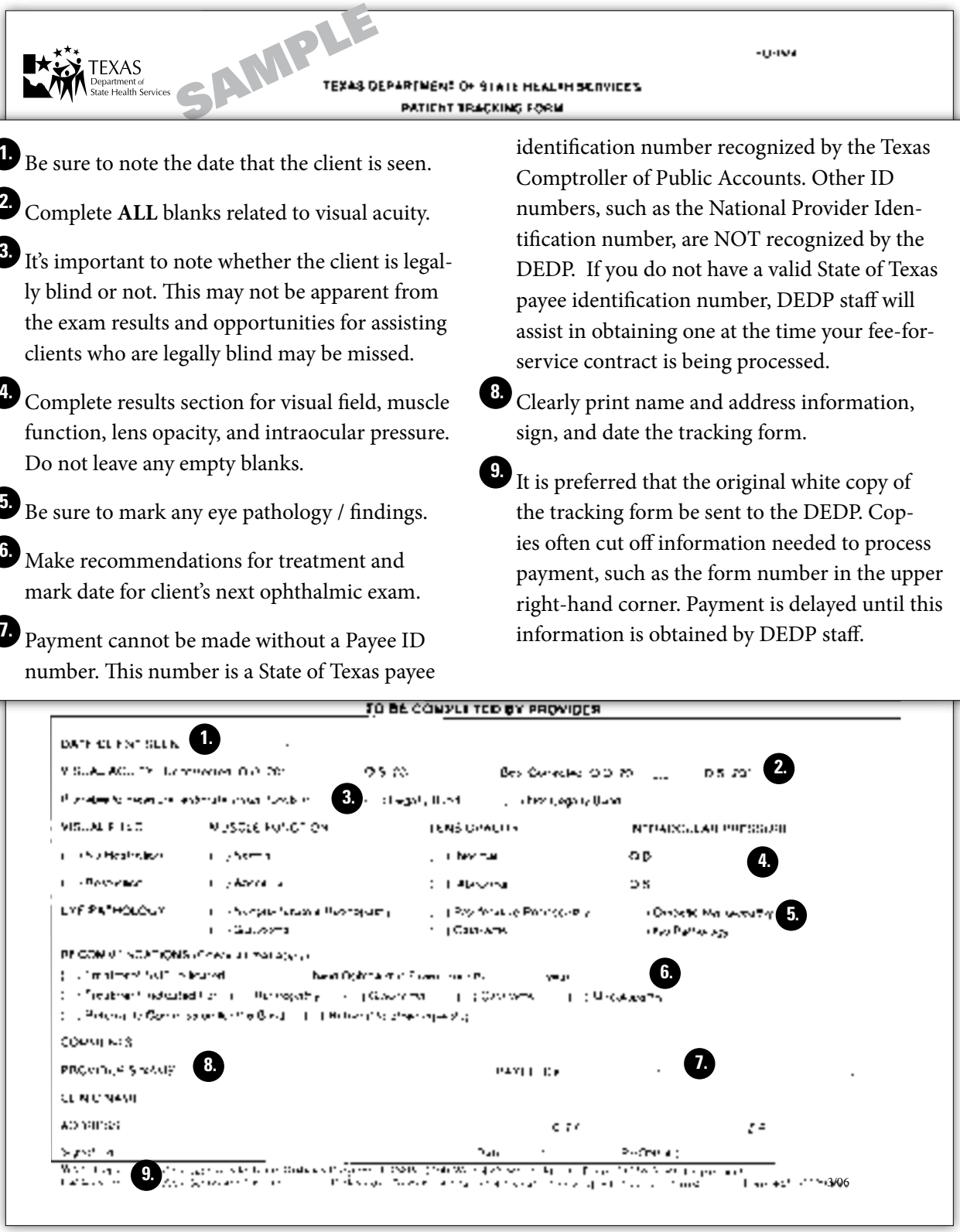
ADDRESS CITY ZIP

Signature Date / PHONE# ( )

[illegible]

[illegible] Form [illegible] 3/06

SAMPLE TRACKING FORM



1. Be sure to note the date that the client is seen.
2. Complete **ALL** blanks related to visual acuity.
3. It's important to note whether the client is legally blind or not. This may not be apparent from the exam results and opportunities for assisting clients who are legally blind may be missed.
4. Complete results section for visual field, muscle function, lens opacity, and intraocular pressure. Do not leave any empty blanks.
5. Be sure to mark any eye pathology / findings.
6. Make recommendations for treatment and mark date for client's next ophthalmic exam.
7. Payment cannot be made without a Payee ID number. This number is a State of Texas payee identification number recognized by the Texas Comptroller of Public Accounts. Other ID numbers, such as the National Provider Identification number, are NOT recognized by the DEDP. If you do not have a valid State of Texas payee identification number, DEDP staff will assist in obtaining one at the time your fee-for-service contract is being processed.
8. Clearly print name and address information, sign, and date the tracking form.
9. It is preferred that the original white copy of the tracking form be sent to the DEDP. Copies often cut off information needed to process payment, such as the form number in the upper right-hand corner. Payment is delayed until this information is obtained by DEDP staff.

DIABETIC EYE DISEASE PROGRAM (DEDP) PAYMENT INFORMATION

DEDP Payment Procedure

The DEDP follows guidelines established by the Texas Comptroller of Public Accounts for processing payments to providers, including the Texas "prompt payment law" which establishes when some types of payments are due. According to the law, payments for goods and services are due 30 days after the goods are provided, the services completed, or a correct invoice is received, whichever is later.

- The DEDP Patient Tracking Form serves as an invoice for services provided. Upon receipt, all tracking forms are date stamped and logged in the DEDP tracking log by Health Promotion Unit (HPU) staff at the Texas Department of State Health Services (DSHS).
- Tracking forms are assessed for accuracy. Incorrect/incomplete forms are returned by fax to the provider or nominator to correct, delaying payment until the corrected tracking form is received.
- Tracking forms are entered into the DEDP database and payment vouchers are issued. Tracking form numbers are used as voucher invoice numbers. All tracking forms must be processed and payment vouchers submitted to DSHS accounts payable/fiscal for payment within 5 working days of receipt of the tracking form (provided the form is accurate and complete). All tracking forms which require follow-up action must be completed within 10 working days of receipt and submitted to accounts payable/fiscal for payment by the 10th working day from receipt.
- Batches of processed vouchers are signed by the Director of the Texas Diabetes Program/Council.
- Vouchers are delivered to DSHS accounts payable/fiscal.
- Accounts payable processes vouchers which are then sent electronically to the Texas Comptroller of Public Accounts.
- Payment is made by the Comptroller in one working day if the voucher received is older than 30 days and less than $5,000. All other vouchers are processed by the Comptroller within seven working days.

Instructions for Direct Deposit of DEDP Payments

Receiving payments by direct deposit is quick and easy and has many advantages over receiving payments by warrant (check).

- No lost or stolen warrants
- Fully traceable payments
- No deposit delays
- Prompt availability of funds
- Improved cash flow

To begin receiving direct deposit payments, simply complete the Vendor Direct Deposit Authorization, DSHS Form #EF29-12503 (Rev. 10-2006), and **send to the Texas Department of State Health Services**:

DSHS Claims Unit (G-209)
Vendor Direct Deposit
Texas Department of State Health Services
1100 West 49th Street
Austin, TX 78756-3199

A copy of the form can be found at the end of this section. The same form (Form 74-176) is available on the Comptroller's *Window on State Government* Web site at:

www.window.state.tx.us/taxinfo/taxforms/74-176.pdf

Advance Payment Notification is available for non-confidential payments. The amount of a direct deposit payment can be sent to you via fax or e-mail one business day before the payment is posted to your bank account. To receive Advance Payment Notification, complete the Advance Payment Notification Authorization, Form 74-193 (12-01) and mail or fax to the Comptroller's Claims Division. The form is available on the Comptroller's Window on State Government Web site at:

www.window.state.tx.us/taxinfo/taxforms/74-193.pdf

Verifying Payments Made by the DEDP for Individual Patients

The Comptroller's State-to-Vendor Web site provides information on payments made on behalf of the DEDP at www.window.state.tx.us/fm/payment:

Click on the State-to-Vendor Payment Information link to prompt a Main Menu screen with four options for accessing payment information:

State Vendor Use Only:

1. Register for a Personal Identification Number (PIN).

Using a PIN enables you to view both your confidential and non-confidential payment information. Logging in with a PIN will allow you to see individual invoice/tracking form numbers covered under a warrant/payment that you will not be able to view when using the public use access option described below.

PIN registration is a 4-step process:

- Provide either your TIN, EIN or SSN.
- Provide a 9-digit warrant number (for authentication purposes) obtained from an uncashed warrant or provide a bank account number set up with the Comptroller's office to receive direct deposits.
- Create a PIN that consists of 6 to 13 alphanumeric characters—you may use special characters.
- Provide your contact information (last name, first name, daytime telephone number and e-mail address).

2. Login to Vendor Payments—PIN Required.

Access your payment information using your existing PIN.

Public Use:

3. Non-confidential Vendor Payments Only— No Security Access Required.

Access non-confidential vendor payment information for payments issued by State of Texas agencies. Payments are identified as non-confidential by the paying state agencies.

The following example of a search for payments made by the DEDP uses the Public Use option for non-confidential vendor payments only. As noted above, logging in with a PIN number will yield additional payment information related to individual Patient Tracking Forms/vouchers used for tracking payments for individual patients.

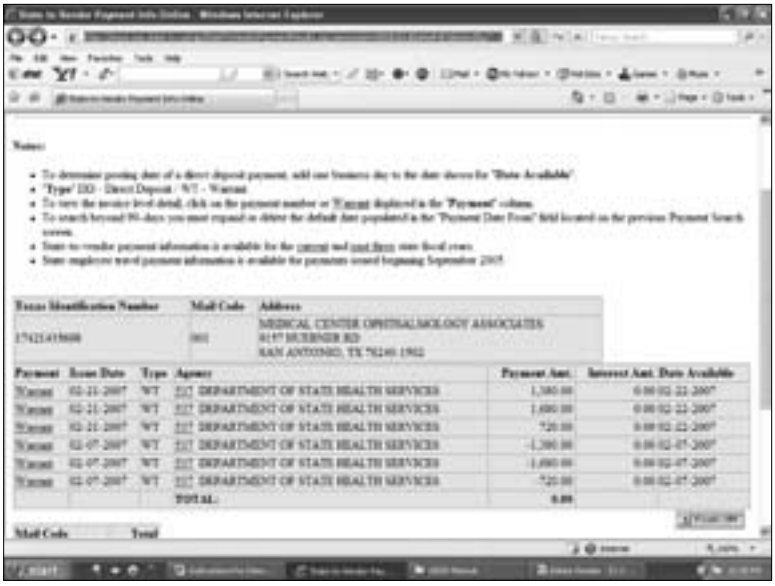
1. Click "Enter" on option 3 on the screen on the previous page.

2. Enter your Texas Identification Number (TIN), Federal Employer Identification Number (EIN), or Social Security Number (SSN). Your ten-digit number should be preceded by the number "1" when you enter it.

3. Enter Agency Number "537" – This is the number for the Texas Department of State Health Services.

4. You may also enter a date range for the period you are searching.

5. Click Search



6. Look at the Issue Date. The DEDP will only verify payments for patients 30 days after the Patient Tracking Form is submitted, since Comptroller guidelines allow for payment up to 30 days after services are provided.

7. Click on "Warrant" in the Payment column.

8. Document # refers to the check number issued (if not direct deposit).

9. To verify payment for patients by name, contact the DEDP at the Texas Department of State Health Services: 1-888-963-7111 ext. 7490. DEDP staff will need the Invoice Number from the screen above to provide the name(s) of the patient(s) whose exams are paid by this warrant.

Using a PIN to access payment information rather than the public access option provides information such as Patient Tracking Form/voucher numbers that can be used to identify payments for individual patients. Logging in with a PIN may eliminate the need to call the DEDP to gather further payment information, since Providers maintain copies of Patient Tracking Forms with numbers to compare with related payment information provided through secure access.

Forms

- Vendor Direct Deposit Authorization
- Advance Payment Notification Authorization

Vendor Direct Deposit Authorization

INSTRUCTIONS

- Use only BLUE or BLACK ink.
- Alterations must be initialed.
- Financial institution must complete Section 4.
- Section 7 must be completed by the paying state agency.
- Check all appropriate box(es).

For further instructions, see the back of this form.

TRANSACTION TYPE

SECTION 1

New setup	Sections (2, 3 & 4)	☐ Change financial institution	(Sections 2, 3 & 4)
☐ **Cancellation**	Sections (2 & 3)	☐ Change account number	(Sections 2, 3 & 4)
☐ Interagency transfer	Sections (2 & 3)	☐ Change account type	(Sections 2, 3 & 4)

PAYEE IDENTIFICATION

SECTION 2

1. Soc. Sec. No. or Fed. Employer's Identification (FEI)		2. Mail Code (If not known, will be completed by Paying State Agency)	
3. Name		4. Business or daytime phone number ( )	
5. Mailing address	6. City	7. State	8. ZIP Code

AUTHORIZATION FOR SETUP, CHANGES OR CANCELLATION

SECTION 3

9. Pursuant to Section 403.016, Texas Government Code. I authorize the Comptroller of Public Accounts to deposit by electronic transfer payments owed to me by the State of Texas and, if necessary, debit entries and adjustments for any amounts deposited electronically in error. The Comptroller shall deposit the payments in the financial institution and account designated below. I recognize that, if I fail to provide complete and accurate information on this authorization form, the processing of the form may be delayed or that my payments may be erroneously transferred electronically.

I consent to and agree to comply with the National Automated Clearing House Association Rules and Regulations and the Comptroller's rules about electronic transfers as they exist on the date of my signature on this form or as subsequently adopted, amended or repealed.

10. Authorized signature	11. Printed name	12. Date

FINANCIAL INSTITUTION *(Must be completed by financial institution representative.)*

SECTION 4

13. Financial institution name	14. City		15. State
16. Routing transit number - -	17. Customer account number	*Dashes required?* ☐ **YES**	18. Type of account ☐ **Checking** ☐ **Savings**
19. Financial institution representative name (Please print)	20. Title		
21. Representative signature (Optional)	22. Phone number ( )		23. Date

FOR INTERNAL USE *(Optional)*

SEC. 5

24. State agency representative	25. Mail code	26. ☐ **Check this box if state agency representative to be notified.**

CANCELLATION BY AGENCY

SEC. 6

27. Reason	28. Date

PAYING STATE AGENCY *(Fiscal Use Only)*

SECTION 7

29. Signature	30. Printed name	
31. Agency name Department of State Health Services		32. Agency number 537
33. Comments	34. Phone number (512) 458-7435	35. Date

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us/ for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004). To find out about your information and your right to request correction, please contact DSHS Claims Unit at (512) 458-7435.

Instructions for Vendor Direct Deposit Authorization

Form #EF29-12503, Vendor Direct Deposit Authorization, is used to set up, change, or cancel direct deposit instructions. Corrections may be made to existing direct deposit instructions by checking the "change" boxes in Section 1.

SECTION 1: **Check the appropriate box(es)**

- **NEW SETUP –** If payee is not currently on direct deposit with this agency.
  - **a.** Complete Sections 2, 3, and 4.
  - **b.** Financial institution representative must complete Section 4.
- **CANCELLATION –** If payee wishes to stop direct deposit with this agency.
  - **a.** Payee completes Sections 2 and 3.
- **INTERAGENCY TRANSFER –** For DSHS use only.
- **CHANGE FINANCIAL INSTITUTION**
  - **a.** Payee completes Sections 2 and 3.
  - **b.** The new financial institution representative completes Section 4.
- **CHANGE ACCOUNT NUMBER**
  - **a.** Payee completes Sections 2 and 3.
  - **b.** Financial institution representative completes Section 4.
- **CHANGE ACCOUNT TYPE**
  - **a.** Payee completes Sections 2 and 3.
  - **b.** Financial institution representative completes Section 4.

SECTION 2: **PAYEE IDENTIFICATION**

Item 1 Leave the shaded boxes blank if you do not have your 11-digit Comptroller Texas Identification Number. The paying state agency will provide the information to be entered in the shaded boxes. Enter your 9-digit social security number or your Employer's Identification Number (EIN). The number entered in this section should be the same number that is currently in use for processing your claims.

Item 2 If your 3-digit mail code is not known, it will be assigned by the paying state agency.

SECTION 3: **AUTHORIZATION FOR SETUP, CHANGES, OR CANCELLATION**

Items 10, 11 & 12 The individual authorizing must sign, print their name, and date the form.

NOTE: No alterations to this section will be allowed.

SECTION 4: **FINANCIAL INSTITUTION**

Section 4 must be completed by a financial institution representative

Item 19 The financial institution representative's name must be provided in Section 4.
NOTE: Alterations to routing and/or account number must be initialed by the financial institution representative or the payee.

SECTION 5: **FOR INTERNAL USE**

The state agency contract manager or field staff may complete this section if they wish to be notified that DSHS Accounting has processed this form.

SECTION 6: **CANCELLATION BY AGENCY**

Sections 6 and 7 must be completed by the paying state agency.

SECTION 7: **PAYING STATE AGENCY**

This section is for DSHS Accounting use only.

Submit the **Original Copy** to: DSHS Claims Unit (G-209)
Vendor Direct Deposit
Texas Department of State Health Services
1100 West 49th St.
Austin, TX 78756-3199

Retain the **Copy** for your records.

74-193
(Rev. 1-06/5)

ADVANCE PAYMENT NOTIFICATION AUTHORIZATION

- For vendors receiving direct deposit payment(s) from the State of Texas.
- For State of Texas employees receiving travel reimbursement payment(s) by direct deposit.
- Instructions for completing this form are printed on the reverse side.

AGENCY USE ONLY

PROCESSED BY: _____ **DATE:** _____

VERIFIED BY: _____ **DATE:** _____

Under Ch. 559, Government Code, you are entitled to review, request, and correct information we have on file about you, with limited exceptions in accordance with Ch. 552, Government Code. To request information for review or to request error correction, contact us at the address listed on this form.

PAYEE IDENTIFICATION *(REQUIRED)*

SECTION 1

1. 11-digit Texas Identification Number (TIN)

2. EIN / SSN. *If TIN is not known, provide a 9-digit Federal Employer Identification Number (EIN) or 9-digit Social Security Number (SSN)*

3. Payee name *(Business / Individual)*

NOTIFICATION and MAIL CODE SELECTIONS

SECTION 2

4. Contact name *(Print)(Required)*

5. Phone number *(Area code)(Required)*

( )

6. Title *(Optional)*

Choose one (1) method to receive your payment notification by providing either an E-mail address or FAX number. *(Must provide one)*

7. E-mail address _____ ☐ Check box if changing an existing E-mail address. Indicate on line 10 the Mail Code(s) where change is needed.

8. FAX number (_____) _____ ☐ Check box if changing an existing FAX number. Indicate on line 10 the Mail Code(s) where change is needed.

9. Payment remittance *(Must select one)*

☐ Check box if you **DO** wish to see payment remittance information on your notification.

☐ Check box if you **DO NOT** wish to see payment remittance information on your notification.

Please indicate the direct deposit mail code(s) for which payment notification is to be sent. If you are unsure about which mail code to use, please skip items 10 and 11. See instructions on back for additional information.

10. New / Add Mail Codes ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐

Please indicate the direct deposit mail code(s) for which you no longer wish to receive an advance payment notification.

11. Delete Mail Codes ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐

AUTHORIZATION *(REQUIRED)*

SECTION 3

I authorize the Texas Comptroller of Public Accounts to send Advance Payment Notifications for the Mail Code(s) indicated and to the E-mail address or FAX number designated in Section 2 above. I understand that payment notifications may include payment information that is considered confidential and therefore exempt from public disclosure.

12. Authorized signature

sign here ▶

13. Date

14. Printed name

15. Title

SUBMIT TO:

SECTION 4

16. Mail address:
TEXAS COMPTROLLER OF PUBLIC ACCOUNTS
Claims Division - Direct Deposit Program
P.O. Box 13528
Austin, TX 78711-3528

OR

17. FAX number:
TEXAS COMPTROLLER OF PUBLIC ACCOUNTS
Claims Division - Direct Deposit Program
(512) 475-5424

Form 74-193 (Back) (Rev. 1-06/5)

INSTRUCTIONS FOR ADVANCE PAYMENT NOTIFICATION

PURPOSE: The Advance Payment Notification option is available to vendors receiving direct deposit payment(s) from the State of Texas, and to State of Texas employees who wish to receive notification of their travel reimbursement payment(s) issued by direct deposit. Notifications provide you with (1) business day advance notice prior to the payment posting to your bank account.

SECTION 1: PAYEE IDENTIFICATION *(Required)*

1. 11-digit TIN: Provide your 11-digit vendor number, referred to as the Texas Identification Number (TIN) or
2. EIN/SSN: If the 11-digit TIN is not known, provide your 9-digit Federal Employer Identification Number (EIN) or your 9-digit Social Security Number (SSN).
3. Payee name: PRINT the name of the business or individual to whom direct deposit payments are made.

SECTION 2: NOTIFICATION and MAIL CODE SELECTIONS

4. Contact name (Required): PRINT the name of the person to be contacted should questions arise regarding this form.
5. Phone number (Required): Provide the area code, phone number and extension (if applicable) for the contact name.
6. Title (Optional): Provide the working title for the contact name.
7. E-mail address: If you wish to receive your advance payment notification by E-mail, on line 7 provide the E-mail address where notification is to be sent. Otherwise, leave line 7 blank and continue with line 8. ☑ Check the box to indicate a change to an existing E-mail address.
8. FAX number: If you wish to receive your advance payment notification by FAX, on line 8 provide the FAX phone number where notification is to be sent. Leave line 8 blank if an E-mail address has already been provided on line 7. ☑ Check the box to indicate a change to an existing FAX number.
9. Payment remittance: ☑ Check the appropriate box to indicate whether or not to include payment remittance information on your notification. Payment remittance can include: the paying state agency's document number; itemized invoice number, description, payment and interest amounts.
10. Add mail codes: Designate up to six direct deposit mail codes for advance payment notification. You may submit a separate form to designate additional mail codes if needed.

> Note: A mail code is a 3-digit number used in the processing of payments to identify a particular mailing address or specify an account for direct deposit payments. If you are unsure about which mail code to use, please leave it blank.

11. Delete mail codes: List mail code(s) for which you no longer wish to receive payment notification.

SECTION 3: AUTHORIZATION *(Required)*

12. Authorized signature: Signature of individual responsible for approving the receipt of Advance Payment Notifications.
13. Date: Provide the date of authorized signature.
14. Printed name: Provide the printed name of authorized signature.
15. Title: Provide the title of authorized person.

SECTION 4: SUBMIT TO:

16. Mail address: Completed form may be mailed to the address in this section.
17. FAX number: Completed form may be faxed to the FAX number provided in this section.

HELPFUL INFORMATION

The Advance Payment Notification Authorization, Form 74-193, and the Vendor Direct Deposit Authorization, Form 74-176, and the Direct Deposit Authorization for state employees, Form 74-158, are available on the Internet at:
http://www.window.state.tx.us/taxinfo/taxforms/74-193.pdf
http://www.window.state.tx.us/taxinfo/taxforms/74-176.pdf
http://www.window.state.tx.us/taxinfo/taxforms/74-158.pdf

Payment remittance, mail code and other types of payment information can be found using the Internet at:
http://www.window.state.tx.us/fm/payment/.

Non-confidential vendor payment information is available by fax by dialing the State-to-Vendor Fax Line at:

English:	**512/936-3461 in Austin**	**877/570-0844 toll free**
Spanish:	**512/936-3462 in Austin**	**877/570-0830 toll free**

For additional information or assistance, please contact the Claims Division by:

E-mail:	**claims.pin@cpa.state.tx.us**
Phone:	**512/936-8138 in Austin or 800/531-5441 Ext. 6-8138 toll free**

DIABETIC EYE DISEASE PROGRAM

FREQUENTLY ASKED QUESTIONS

1. Does the patient need a social security number?

No. Nominators may leave this space blank on the patient tracking form if the patient does not have a social security number. However, the patient must show evidence of Texas residency to receive services through the Diabetic Eye Disease Program .

2. What can be used as proof of Texas residence?

Proof of residence may include a voter registration card, rent/mortgage receipt, mortgage company, utility bill/receipt/records, official records of ownership of property, employer, Texas Motor Vehicle Commission (DMV), school or day care records, child care provider, home visit, DPS ID, non-relative, post office records, mail received with name and address, telephone directory, city or crisscross directory, church or baptismal record, Texas driver's license (valid), and VolAg Form 1857 Landlord Verification.

3. Can a nominator refer a patient to an ophthalmologist?

Yes, provided the ophthalmologist is on the Diabetic Eye Disease Program approved provider list for their region or area.

4. What if the doctor wants to see the patient again for a follow-up exam?

A patient is eligible to receive one initial dilated funduscopic eye exam and two follow-up exams per year. The ophthalmologist or optometrist conducting the initial eye exam should contact the patient's primary care provider to indicate that a follow-up exam is needed. The nominator will then schedule the follow-up visit for the patient, initiating a new patient tracking form for each exam.

5. If the patient needs treatment will the program pay for it?

No, the Diabetic Eye Disease Program does not pay for any diagnostic tests such as fluorescein angiography, treatment procedures (laser treatment or surgery), or medications. Prescription eyewear or corrective lenses are also not covered by the program.

6. Does the patient need to be a citizen of the United States?

No. The Diabetic Eye Disease Program requires that patients be Texas residents. See question two for documents that may be used as proof of residence.

7. How many visits will the DEDP pay for?

A patient is eligible to receive one initial dilated funduscopic eye exam and two follow-up exams per year.

8. The patient tracking form requires a date for when the patient was diagnosed with diabetes (type 1 or type 2). This is used to determine patient eligibility. What if the patient does not remember when they were diagnosed?

Nominators should refer to the patient's medical record and determine a date of diagnosis. While patients with type 2 diabetes are eligible regardless of how long they've had diabetes, it is important for health care providers to be aware of the date of diagnosis in order to accurately evaluate the patient's risk for diabetic eye disease.

Patients with type 1 diabetes must have been diagnosed for five or more years before they are eligible to receive services through the Diabetic Eye Disease Program.

9. Why are the results of an A1c test or blood pressure check required on the patient tracking form?

A1c and blood pressure are key indicators of the patient's ability to control their diabetes and the resulting risk for developing eye disease. Health care providers should consider this information when determining need for follow-up and additional counseling or education to assist the patient in improving control of their diabetes.

10. If I run out of tracking forms, can copies be made?

No. Tracking forms are assigned a unique number used to track each patient exam and facilitate provider payment for that exam. Copies of forms with the same tracking number would indicate payment for only one exam, even if multiple exams were provided. It is important to use only forms ordered through the Diabetic Eye Disease Program in order to accurately record each eye exam. Exams recorded on copies of original forms obtained through the program or DSHS are not eligible for payment by the program.

11. Why do I need to provide the patient a copy of the privacy notification each time we complete a patient tracking form?

With few exceptions, patients have the right to request and be informed about information that the State of Texas collects about them. They are entitled to receive and review the information upon request. They also have the right to ask the state agency to correct any information that is determined to be incorrect.

12. How much can a provider be reimbursed for each eye exam?

Providers are reimbursed $60 for each eye exam.

13. If a patient is diagnosed with diabetic eye disease and no local resources exist for treatment, how can treatment services be obtained for that patient?

The Department of Assistive and Rehabilitative Services / Blind Services (formerly Texas Commission for the Blind) may reimburse for treatment as part of vocational or independent living services offered to eligible patients. A number of private, non-profit organizations also may be able to provide assistance with certain treatments (see "Resources" on the following page for more information).

14. A patient tracking form was returned due to incomplete information or missing signatures. What happens next?

A patient tracking form is returned to the nominator if there is incomplete patient or nominator information, unanswered eligibility questions, or signatures missing. In any situation, the provider will not be paid until required information has been entered on the form and returned to the Diabetic Eye Disease Program. Time spent returning patient tracking forms and waiting for completed forms to be returned will often delay payment for up to two months.

Therefore, it is crucial that forms be thoroughly examined for missing information (see instructions for completing patient tracking forms). Because payment can be delayed, provider offices should be aware of required information that the nominator must provide when making a referral and assure that it is included on the patient tracking form, along with completed provider information, before submitting for payment.

15. Can a patient be sent to a different provider if the patient receives an initial exam and requests a second opinion?

No. Referral to a new provider cannot be made based on the patient's request for a second opinion. However, if the eye care provider conducting the exam feels an additional dilated funduscopic exam is needed by another eye care provider (a consulting physician), the patient may be referred as long as that provider is on the approved Diabetic Eye Disease program provider list. This second referral constitutes a follow-up exam for the patient, under the program guidelines.

RESOURCES

Eye Care Assistance

Eye Care America

655 Beach St.
San Francisco, CA 94109-1336
1-800-222-3937
www.eyecareamerica.org
Note: Also provides assistance with medications

Blindness Education, Screening, and Treatment (BEST) Program

Division for Blind Services
Texas Department of Assistive and Rehabilitative Services (DARS)
1-800-628-5115
www.dars.state.tx.us/dbs/best/
DBSinfo@dars.state.tx.us

Statewide Organizations

Children's Health Insurance Program in Texas (CHIP)/ Children's Medicaid

1-800-647-6558, 1-877-543-7669
fax: 1-877-542-5951
www.chipmedicaid.org

Families can apply for CHIP using a toll-free phone number or a mail application.

Medicaid

Texas Department of Human Services
Statewide: 1-800-252-8263
www:hhsc.state.tx.us/medicaid/index.html

Information on Medicaid eligibility and coverage.

Children with Special Health Care Needs (CSHCN, formerly CIDC)

Phones: 1-800-252-8023, or 1-800-422-2956 (Family Health Services)
Fax: 512-458-7417
www.dshs.state.tx.us/cshcn

Children with Special Health Care Needs (formerly CIDC) provides state-funded assistance for children with type 1 and type 2 diabetes for services not covered by Medicaid, CHIP, private insurance, or third party payors.

Texas Diabetes Program/Council

Texas Department of State Health Services
1100 West 49th Street
Austin, Texas 78756
(512) 458-7490, 1-888-963-7111 ext. 7490
www.texasdiabetescouncil.org

The Texas Diabetes Council was established by the Texas Legislature in 1983. The Council works with private and public organizations to promote diabetes prevention and awareness of quality care. They develop, implement and monitor a state plan for diabetes control. Free educational materials are available.

Texas Department of State Health Services Audiovisual Library

1100 West 49th Street, Mail Code 1975
Austin, TX 78756-3199
1-888-963-7111 ext. 7260
TDD: 512-458-7708
www.dshs.state.tx.us/avlib/default.shtm

Offers free loan of audiovisual materials to Texas residents on a number of health and safety topics.

HHSC (Health and Human Services Commission) Office of the Ombudsman

1-877-787-8999
Fax: 512-491-1067
TDD Hotline 888-425-6889 or 512-438-3087 (not toll free)

The Office of the Ombudsman was created to assist the public with health and human services-related complaints or issues.

National Organizations

American Association of Diabetes Educators
100 West Monroe, 4th Floor
Chicago, IL 60603
1-800-338-3633
1-800-832-6874 for diabetes educators in your area
www.aadenet.org

American Diabetes Association
1660 Duke Street
Alexandria, VA 22314
1-800-342-2383 (DIABETES)
1-800-232-6733 (ADA ORDER)
to order publications
www.diabetes.org

American Dietetic Association
120 South Riverside Plaza, Suite 2000
Chicago, IL 60606-6995
1-800-877-1600
Consumer Nutrition Hotline:
1-800-366-1655 (Spanish speaker available); has a list of registered dietitian in your area
www.eatright.org

Centers for Disease Control and Prevention
Division of Diabetes Translation
4770 Buford Highway, NE, Mailstop K-10
Atlanta, GA 30341-3717
1-800-232-4636
TTY: 1-888-232-6348
1-877-CDC-DIAB (232-3422)
www.cdc.gov/diabetes

Joslin Diabetes Center
One Joslin Place
Boston, MA 02215
(617) 732-2400
www.joslin.org

Juvenile Diabetes Research Foundation International
120 Wall St., 19th Floor
New York, NY 10005-4001
1-800-533-2873 (JDF-CURE)
www.jdf.org email: info@jdrf.org

Medic Alert Foundation International
2323 Colorado Avenue
Turlock, CA 95382
1-800-ID-ALERT (432-5378), or 1-888-633-4298
www.medicalert.org

For medical information jewelry and national registry service.

Diabetes Research and Wellness Foundation
5151 Wisconsin Ave., NW, Suite 420
Washington, D.C. 20016
www.diabeteswellness.net

National Diabetes Information Clearinghouse
1 Information Way
Bethesda, MD 20892-3560
(301) 654-3327
1-800-860-8747
ndic@info.niddk.nih.gov
www.niddk.nih.gov

National Diabetes Education Program
One Diabetes Way
Bethesda, MD 20814-9692
1-800-438-5383
www.ndep.nih.gov

Publications and Audiovisual Resources
American Diabetes Association, American Dietetic Association, and the other organizations listed above have educational publications and audiovisual materials available, some at no cost. The list of other materials is only a sampling of diabetes education materials. The public library, local health department, local hospital, and heart association are also sources for information.

Books and Brochures

Texas Diabetes Program/Council
Texas Department of State Health Services
1100 West 49th Street
Austin, TX 78756
(512)458-7490
www.texasdiabetescouncil.org

Offers more than 20 free publications, English and Spanish, in easy-to-read formats. For example, "Food for Life: Living Well with Diabetes" is a booklet describing healthy eating habits and dietary choices.

United States Department of Agriculture
Food and Nutrition Information Center
www.nal.usda.gov/fnic
1-800-687-2258

Food Guide Pyramid – Copyright free materials that can be downloaded from Internet Weight-control Information Network

National Institute for Diabetes & Digestive & Kidney Disease (NIDDK)
1 WIN Way
Bethesda, MD 20892-3665
1-800-WIN-8098; (301) 984-7378
email: win@info.niddk.nih.gov

Diabetes Health
6 School St.
Suite 160
Fairfax, CA 94930
1-800-234-1218
fax: (415) 258-2822
www.diabeteshealth.com

Diabetes Interview (monthly)
P.O. Box 668
Fairfax, CA 94978-0668
1-800-488-8468
Fax 1-800-559-0031

Diabetes Self-Management
P.O. Box 51125
Boulder, CO 80323-1125
Diabetes Wellness Letter
DRWF, P.O. 231
Shrub Oak, NY 10588

Practical Diabetology
150 22nd Street
New York, NY 10011

Voice of the Diabetic
Free upon Request
811 Cherry Street, Ste. 309
Columbia, MO 65201-4892

Patient Magazines/Print

Diabetes Digest
5 South Myrtle Ave.
Spring Valley, NY 10977
(845) 426-7612
fax: (845) 426-7512

Diabetes Forecast
www.diabetes.org/diabetes-forecast.jsp

Patient Magazines/Online

Children with Diabetes
www.childrenwithdiabetes.com

Helps kids with diabetes and their families learn about diabetes, meet people with diabetes, and help others with diabetes.

Diabetic Gourmet
www.diabeticgourmet.com

Online magazine dedicated to healthy eating, diabetes, and diabetes-related health issues, with news, recipes, articles, forums, tools, and more.

Diabetic Lifestyle Online Magazine
www.diabetic-lifestyle.com

Includes recipes, menus, medical updates, and practical information on managing diabetes on a daily basis.

Online Resources/Chat Rooms

Diabetic-Lifestyle Just for Kids
www.diabetic-lifestyle.com/forkids.htm

Children with DIABETES
www.childrenwithdiabetes.com

Diabetes Chat
www.diabetesCHAT.net

Must be 18 years old to participate

Medication Assistance & Information

Abbot Diabetes Patient Assistance Program
1-866-224-8887
www.abbottdiabetescare.com

American Diabetes Supply, Inc.
1-800-453-9033, ext. 611
www.americandiabetessupply.com

B-Scientific Diabetes Centre
1-800-544-5969
877-505-5545 (fax)
www.bscientific.com

Serves Medicaid, CHIP, CSHCN, & commercial enrollees

Care Entrée
(972) 522-2000
www.careentree.com

Cost Containment Research Institute
(202) 318-0770
4200 Wisconsin Ave NW, Suite 106-222
Washington, DC 20016
www.institutedc.org

Free Drug Card
www.freedrugcard.us

Free Medicine Foundation
(573) 996-3333
www.freemedicinefoundation.com/index.html

Free Medicine Program
1-800-921-0072
www.freemedicineprogram.com

FREEDOMED
1-888-722-7556
www.freedomed.com

The Health and Wellness Education Center
(205) 652-6557
tydebra3@aol.com

HealthCove
1-800-796-5558
www.healthcove.com

Medicare Prescription Drug Plans
1-800-633-4227
www.medicare.gov/MPDPF/Shared/Static/Resources.asp

The Medicine Program
1-866-694-3893
www.themedicineprogram.com

National Diabetes Information Clearinghouse
www.diabetes.niddk.nih.gov/dm/pubs/financial-help/index.htm

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
1-800-860-8747
Publication: "Financial Help for Diabetes Care"

NeedyMeds
www.needymeds.com

Partnership for Prescription Assistance (PPA)
1-888-477-2669
www.pparx.org

Pfizer
1-866-776-3700
www.pfizerhelpfulanswers.com

2 programs: Connection to Care & Pfizer Pfriends—not age-mandated

Note: Cannot have insurance to quality for this program

RxAssist
www.rxassist.org

State Pharmaceutical Assistance Programs
www.ncsl.org/programs/health/drugaid.htm

Together RX
1-800-865-7211
www.Together-RX.com

Veterans Prescription Service
1-877-222-8387
www.va.gov/healtheligibility

Advocacy

Advocacy, Inc.
7800 Shoal Creek Blvd., #171-E
Austin, TX 78757-1024
1-800-252-9108

Patient Advocate Foundation
1-800-532-5274
www.patientadvocate.org

Children's Resources

Marathon Kids
www.marathonkids/com/site/

Shriners Hospitals
1-800-237-5055

Texas Children's Hospital
(832) 822-3670
www.texaschildrenshospital.org/CareCenter/Diabetes

Camps

ADA Diabetes Camps
www.diabetes.org/communityprograms-and-locallevents/diabetescamps.jsp

Each summer, there are day camps and 1- to 3-week camping sessions for children with type 1 diabetes. Tuition assistance is available based on financial need.

Texas Lions Camp
P.O. Box 247
Kerrville, TX 78029-0247
(830) 896-8500

Camp serves children, ages 7-17, who use insulin.

Texas Children's Hospital Diabetes Summer Camp
Corpus Christi, TX
Contact: Patsy Reyes at (361) 694-5434

Government Resources

Centers for Disease Control
Division of Diabetes Translation
www.cdc.gov

National Institutes of Health
www.nih.gov

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
www.niddk.nih.gov

General Information

Maternal and Child Health Library
www.mchlibrary.info/KnowledgePaths/kp_diabetes.html

Language Translation

CDC's "Take Charge of Your Diabetes" is available in 9 languages. For translations, access the following site: www.hawaii.gov/health/family-child-health/chronic-disease/diabetes/resourcesandtools.html

Pump Training

Animas: Animas Pump Company
1-877-937-7867

MiniMed: Medtronics
1-800-999-9859

Cosmo Pump: Deltec
1-800-544-4734

Primary Care Service Sites

Texas Association of Community Health Centers
www.tachc.org

U.S. Department of Health and Human Services (DHHS)
Health Resources and Services Administration (HRSA)
ask.hrsa.gove/pc/

Support Services

Family Support Network
www.childrenwithdiabetes.com/fsn/

Insurance Information

Health Insurance Consumer Guides
www.heatlhinsuranceinfo.net

Insure Kids Now!
1-877-543-7669
www.insurekidsnow.gov

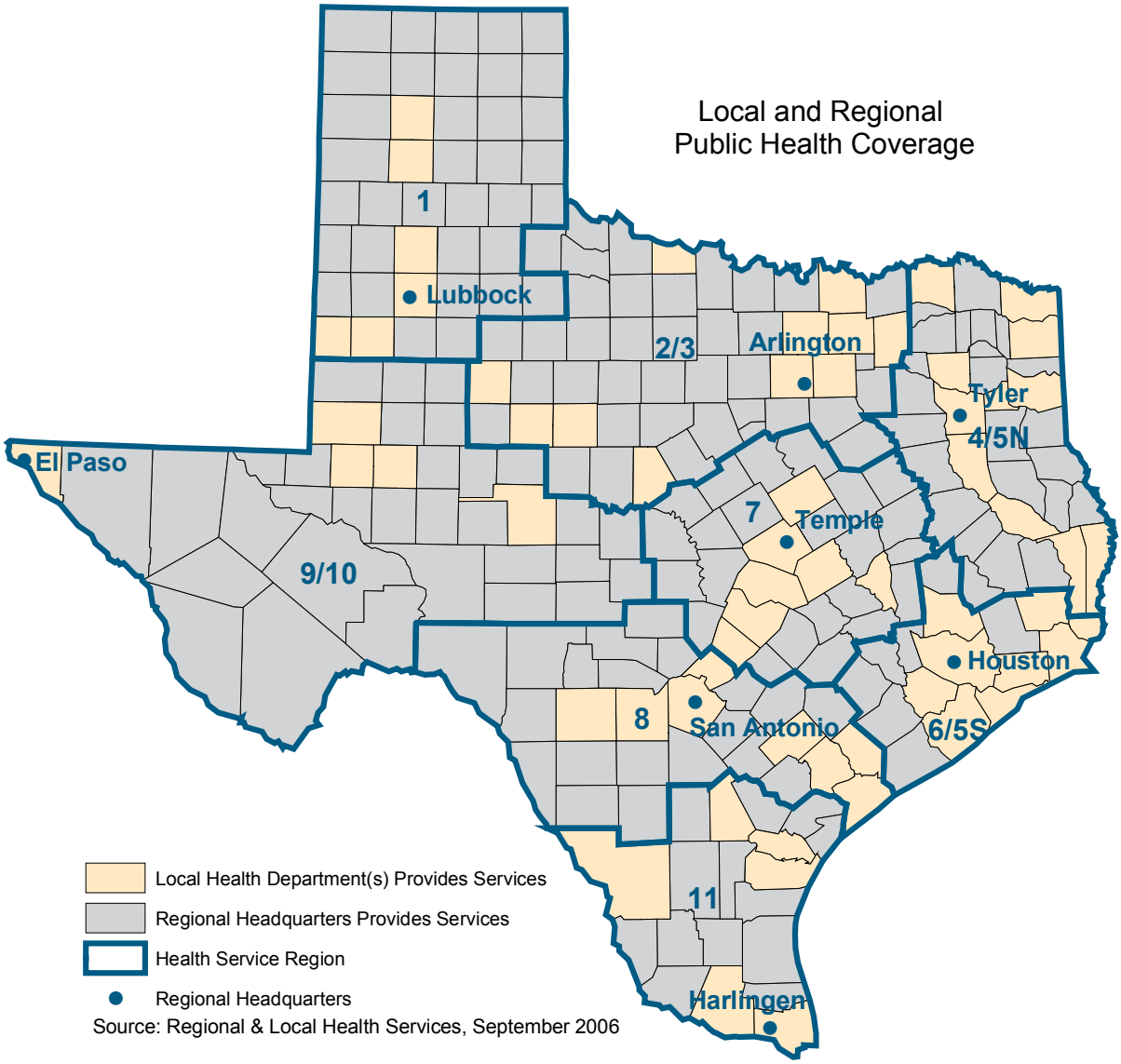
Medicaid
1-877-267-2323

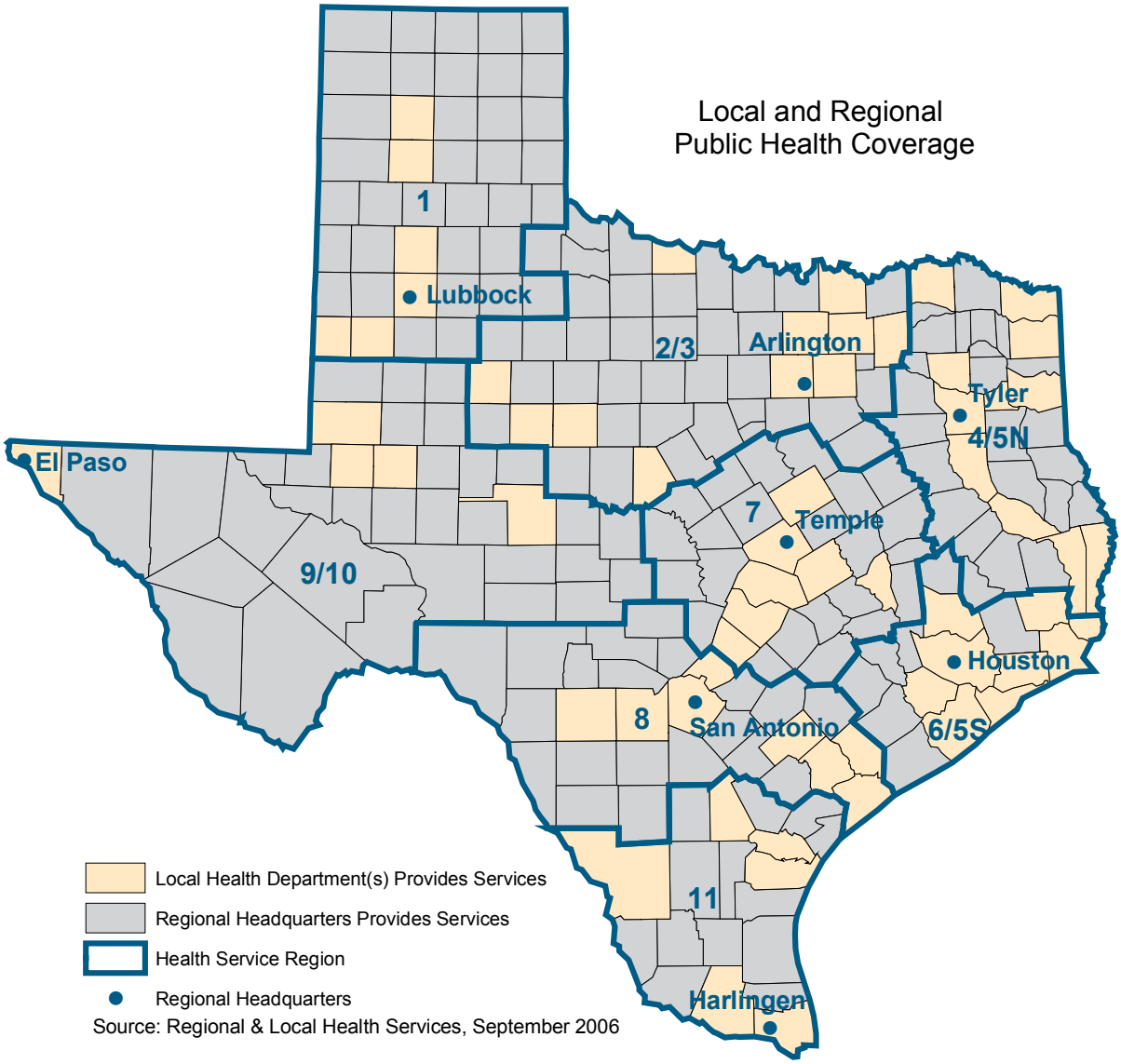
State Children's Health Insurance Program
1-877-543-7669
www.cms.hhs.gov/home/schip.asp

The Texas Department of Insurance
333 Guadalupe
Austin, TX 78701

or

P.O. Box 149104
Austin, TX 78714-9104
1-800-578-4677 (in Texas), (512) 463-6169
Consumer Helpline 1-800-252-3439, or
(512) 463-6515 in Austin www.tdi.state.tx.us


Local and Regional
Public Health Coverage
1
Lubbock
2/3
Arlington
Tyler
4/5N
El Paso
7
Temple
9/10
Houston
8
San Antonio
6/5S
11
Harlingen
Local Health Department(s) Provides Services
Regional Headquarters Provides Services
Health Service Region
Regional Headquarters
Source: Regional & Local Health Services, September 2006


Local and Regional
Public Health Coverage
1
Lubbock
2/3
Arlington
Tyler
4/5N
El Paso
7
Temple
9/10
Houston
8
San Antonio
6/5S
11
Harlingen
Local Health Department(s) Provides Services
Regional Headquarters Provides Services
Health Service Region
Regional Headquarters
Source: Regional & Local Health Services, September 2006